

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER California Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 909 S Lake Street Los Angeles, CA 90006	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to ensure blood sample was collected from one of three sampled residents (Resident 1). For Resident 1, the facility failed to obtain blood sample on 11/10/25 for complete blood count (CBC, a group of blood tests that measure the number and size of the different cells in the blood), basic metabolic panel (BMP, a group of blood tests that provides information about the body's metabolism), c-reactive protein (CRP, blood test to check inflammation in the body) and erythrocyte sedimentation rate (ESR, blood test that can show inflammatory activity in the body) as ordered by the physician on 11/7/25. This deficient practice had the potential for the facility not to meet the needs of Resident 1. During a review of the admission Record indicated the facility admitted Resident 1 on 8/15/25 with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the cervical region (upper part of the spine), right ankle and foot and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of the Minimum Data Set (MDS, resident screening tool) dated 8/19/25 indicated Resident 1 had moderately impaired cognitive skills. Resident 1 needed substantial assistance (helper does more than half the effort) with toileting hygiene, shower/bathe, upper/lower body dressing, putting on/taking off footwear, supervision with oral hygiene and set up with eating. During a review of the History and Physical dated 8/17/25 indicated Resident 1 had the capacity to make medical decisions. During a review of the Physician Order dated 11/7/25 at 11:53 a.m., indicated a physician order to obtain blood sample for CBC, BMP, CRP and ESR from Resident 1 to be done on 11/10/25. During a review of the Laboratory Patient Service Log dated 11/10/25 indicated Resident 1's name was entered in the log. Written across Resident 1's name was Resident 1 refused. The Service Log was signed by licensed vocational nurse (LVN 1). During an interview on 11/13/25 at 8:32 a.m., Resident 1 stated he was waiting to have his blood sample collected but nobody showed up on 11/10/25. Resident 1 stated he was informed that he refused to have his blood sample collected. Resident 1 stated he did not refuse. During a telephone interview on 11/13/25 at 9:11 a.m., LVN 1 stated the laboratory technician came on 11/10/25 at around 4:30 am. LVN 1 stated she overheard Resident 1 refused to have his blood sample collected on 11/10/25 but LVN 1 stated she did not document Resident 1 refused. During a concurrent interview and record review on 11/13/25 at 9:23 a.m., Resident 1's nursing progress notes and the Laboratory Service Log were reviewed with the registered nurse supervisor (RNS 1). RNS 1 stated the service log indicated that Resident 1 refused to have his blood drawn and LVN 1 signed the logbook. RNS 1 stated she was unable to find documentation in Resident 1's progress notes that Resident 1 refused. RNS 1 stated there should be documentation that Resident 1 refused the blood draw so we will know what happened. RNS 1 further added she called the laboratory to have Resident 1's blood drawn on 11/10/25, but the laboratory was busy. RNS 1 stated the blood draw was done on 11/12/25 instead. During an interview on 11/13/25 at 10:37 a.m., the director of nursing (DON) stated there should be documentation that Resident 1 refused the blood draw. DON further added when Resident 1 refused the blood draw, Resident 1's physician should have been notified. During a review of the facility Policy titled Laboratory Services revised on 1/25 indicated laboratory, radiology or other diagnostic services ordered by the physician will be completed in a timely manner. The same Policy indicated the facility strives to meet the needs of residents with regard to the quality and/or timeliness of providing laboratory services and reporting laboratory results. During a review of the facility Policy titled Documentation Policy revised on 1/25 indicated deviations from policy and procedures (i.e. resident refused) should be charted in nursing or other notes.</p>		